TRAUMATIC INJURY PROTECTION (TSGLI)
UNDER THE SERVICEMEMBERS' GROUP LIFE INSURANCE PROGRAM

Administered by the Office of Servicemembers' Group Life Insurance

Claim for Traumatic Injury Protection (TSGLI) Payment

Please submit your completed claim to your branch of service below.

TSGLI Branch of Service Contacts				
Branch	**Contact Information**	**Submit Claim by Fax**	**Submit Claim by E-mail**	**Submit Claim by Postal Mail**
Army All Components	Phone: (800) 237-1336 Website: www.tsgli.army.mil	(866) 275-0684	tsgli@hoffman.army.mil	Department of the Army Traumatic SGLI (TSGLI) 200 Stovall Street Alexandra, VA 22332-0470
Marine Corps All Components	Phone: (877) 216-0825 or (703) 432-9277 Website: www.manpower.usmc.mil/ TSGLI	(888) 858-2315	t-sgli@usmc.mil	HQ, Marine Corps Attn: MI-TSGLI 3280 Russell Road Quantico, VA 22134
Navy All Components	Phone: (800) 368-3202 Website: www.npc.navy.mil/CommandSupport/ CasualtyAssistance/FSGLI/TSGLI	(901) 874-2265	MILL_TSGLI@navy.mil	Navy Personnel Command Attn: PERS-62 5720 Integrity Drive Millington, TN 38055-6200
Air Force Active Duty	Phone: (800) 433-0048 Website: ask.afpc.randolph.af.mil	(210) 565-2348	afpc.casualty@randolph.af.mil	AFPC/DPFCS 550 C Street West, Suite 14 Randolph AFB, TX 78150-4716
Air Force Reserves	Phone: (800) 525-0102	(303) 676-6255	ramon.roldan@arpc.denver.af.mil	HQ, ARPC/DPPE 6760 E Irvington Place, #4000 Denver, CO 80280-4000
Air National Guard	Phone: (703) 607-0901	(703) 607-0033	tsgliclaims@ngb.ang.af.mil	NCOIC, Customer Operations Air National Guard Bureau 1411 Jefferson Davis Hwy Suite 10718 Arlington, VA 22202
Coast Guard	Phone: (202) 267-1648	(202) 267-4823	twalsh@comdt.uscg.mil	Commandant, US Coast Guard Attn: CG-12222 100 2ND St, NW Washington, DC 20593-0001
Public Health Services	Phone: (301) 594-2963	(301) 594-2973 or (800) 733-1303	compensationbranch@psc.hhs.gov	PHS Compensation Branch Parklawn Building 5600 Fishers Lane, Rm 4-50 Rockville, MD 20857
NOAA Corps	Phone: (301) 713-3444	(301) 713-4140	Director.cpc@noaa.gov	U.S. Dept. of Commerce, NOAA 8403 Colesville Rd, Suite 500 Silver Spring, MD 20910

GENERAL INFORMATION

WHO IS ELIGIBLE

Effective December 1, 2005, service members who are insured under SGLI and suffer a qualifying loss as a result of a traumatic event are eligible to receive payment for a total amount not less than $25,000 and not greater than $100,000. Service members who were injured between October 7, 2001 and November 30, 2005 in the theaters of operation for Operation Enduring Freedom or Operation Iraqi Freedom also be eligible for TSGLI payment. Members should contact their branch of service for more information.

HOW TO FILE A TSGLI CLAIM

Filing a TSGLI claim is a three step process in which the service member [or guardian or attorney-in-fact], the attending medical professional and the member's branch of service must complete the appropriate parts of the form as follows:

Step 1	Step 2	Step 3
The service member [or guardian or attorney-in-fact]…	The attending medical professional…	The member's branch of service…
must complete Part A of the form and give it to a medical professional to complete Part B.	must complete Part B and return Part A & B to the branch of service.	must certify the claim and forward it to the Office of Servicemembers' Group Life Insurance.

If you have questions about completing the form or if the member is deceased, please contact your branch of service listed on the front cover of this form.

HOW THE TSGLI PAYMENT WILL BE MADE

There are three methods of payment for TSGLI benefits:

1. Electronic Funds Transfer (EFT)
2. Prudential's Alliance Account®*
3. Check

1. Electronic Funds Transfer (EFT)
The TSGLI benefit will be electronically credited to the bank account specified. Depending on the member's bank, payments will be credited three to five days from the date the payment is authorized.

Note: If the member does not choose EFT and there is no guardian or attorney-in-fact, the payment will be made through Prudential's Alliance Account.

2. Prudential's Alliance Account®*
The benefit will be deposited into Prudential's Alliance Account in the member's name and the member will receive a checkbook. The Alliance Account is a personal interest-bearing account that gives the member ready access to the money, whenever it is needed. To use the account, the member can simply write a check. The member may write checks as the money is needed or write out one check for the entire amount and close the account. The account will continue to earn interest as long as any balance is maintained in the account.

3. Check
Payment will be made by check only to a guardian or attorney-in-fact. This option is not available to the member.

WHO WILL RECEIVE THE TSGLI PAYMENT

The TSGLI payment will be made directly to the member. If the member is incompetent, payment will be made to the guardian or attorney-in-fact under the appropriate letters of guardianship, conservatorship, or a power of attorney.

If the member dies after qualifying for payment, the payment will be made to the member's current listed SGLI beneficiary(ies). The member must survive for seven days (168 hours) from the date of the traumatic event to be eligible for TSGLI.

* Open Solutions BIS, Inc. is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Check clearing is provided by JPMorgan Chase Bank, N.A. and processing support is provided by Integrated Payment Systems, Inc. Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC). Open Solutions BIS, Inc., JPMorgan Chase Bank, N.A., and Integrated Payment Systems, Inc. are not Prudential Financial companies.

INSTRUCTIONS FOR COMPLETING THE FORM

Social Security Number (pages 4 through 13) – The service member, guardian, or attorney-in-fact must complete the service member's Social Security Number in the upper right corner on each of these pages.

PART A (pages 4 through 6) **– Member's Identifying Information and Authorization** - to be completed by the member, guardian or attorney-in-fact.

Section 1 – Service Member Information-Complete the identifying information for the member who is requesting TSGLI benefits.

Section 2– Guardian or Attorney-in-fact Information
The guardian or attorney-in-fact should complete this section if he or she is going to receive payment on behalf of the member or if the member is incapable of signing the form. If this section is completed, the guardian or attorney-in-fact must attach one of the following three items: 1. letters of guardianship, 2. letters of conservatorship, **or** 3. power of attorney.

Section 3– Payment Information
Check the box next to one of the three payment methods and follow the instructions below (see page 2 for payment option information).

Electronic Funds Transfer (EFT)	**Prudential's Alliance Account®** (not available to guardian or attorney-in-fact).	**Check** (not available to member).
Fill in all banking information as indicated on the diagram.	Complete the street address to which the checkbook should be sent. The checkbook will be sent via overnight delivery and cannot be sent to a PO Box.	The check will be mailed to the guardian or attorney-in-fact.

Note: If a member does not indicate a payment method the TSGLI benefit will be paid through Prudential's Alliance Account®. If a guardian or attorney-in-fact does not select a payment method, the TSGLI benefit will be paid by check.

Section 4 – Signature
The member, guardian, or attorney-in-fact must sign section 4. If the guardian or attorney-in-fact completes this section, they must also indicate their authority to act on behalf of the member (e.g. guardian, conservator, etc.).

Section 5 – Authorization to Speak With Third Party
The member, guardian, or attorney-in-fact must complete and sign section 5 if someone other than the member, guardian or attorney-in-fact will speak with OSGLI and/or the branch of service about the TSGLI claim.

Section 6 – Authorization to Release Information-The member, guardian, or attorney-in-fact must complete and sign section 6.

PART B (pages 7 through 9) – Medical Professional's Statement – to be completed by the Attending Medical Professional **ONLY**

Section 1 – Patient and Injury Information
Complete the patient's name and the date and diagnosis of the patient's injuries. If the patient is deceased, insert the date, time and cause of death.

Sections 2 through 10 – Losses Suffered by the Patient
Complete the information about each loss being claimed by the patient. Check yes or no in each section to indicate if that particular loss is being claimed. If the member is claiming inability to perform activities of daily living, complete the ADL Questionnaire on pages 10 and 11.

Section 11 – Medical Professional's Comments
Complete any additional information about the patient's injuries. When a narrative description is required, please be complete and concise.

Section 12 – Medical Professional's Information-Fill in identifying information.

Section 13 – Medical Professional's Signature
Indicate whether the medical statement was completed based on observation of the patient's loss or review of the patient's medical records. Sign and date the medical statement.

ADL Questionnaire – Complete the questionnaire as instructed, if applicable.

PART C (pages 12 through 13)– Certification by Branch of Service – to be completed by the branch of service TSGLI certifying official **ONLY**

Section 1 – Traumatic Event Information
Complete the information about the traumatic event that caused the member's injury and loss. If the service member is deceased, please submit a copy of the Report of Casualty (DD-1300) or death certificate and Form SGLV-8286, indicating the SGLI beneficiaries.

Section 2 – Certification by Branch of Service
Check yes or no to certify that the member's injuries and resulting loss as well as the event that caused the member's loss qualifies under 38 CFR 9.20. If the member does not qualify for payment, indicate the reason by checking the appropriate box and provide any explanation necessary in the comments box.

Note: If the member does not qualify because the member had declined SGLI coverage, please submit a copy of the Form SGLV-8286 indicating the declination.

Sections 3 and 4 – Certifying Signature/Additional Comments
Complete the identifying information, sign and date the certification, and provide any additional comments as necessary.

Clear Form Print Form

Service member's Social Security Number

PART A - Member's Identifying Information and Authorization - to be completed by the member, guardian or attorney-in-fact.

1 Service member Information

First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY) | Gender ☐ Male ☐ Female | Marital Status ☐ Divorced ☐ Married ☐ Single ☐ Widowed

Branch of Service | ☐ Active Duty ☐ National Guard ☐ Reserves | Telephone

Address of Record (number and street) | Apartment (if any)

City | State | ZIP Code

E-mail Address

2 Guardian or Attorney-in-fact Information

Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will delay payment of the claim.

If a guardian or an Attorney-in-fact will receive payment, please complete the following:

First Name | MI | Last Name

Mailing Address (number and street) | Apartment (if any)

City | State | ZIP Code

Telephone Number | Fax Number

3 Payment Information

(Please select only **one** of the three methods)

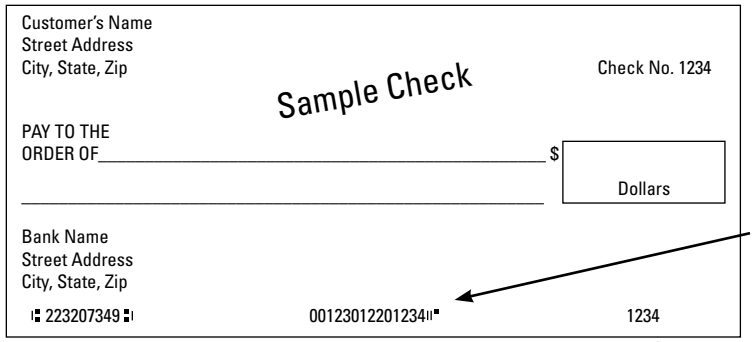
☐ **Payment Option 1 - Electronic Funds Transfer (EFT)** To have the payment deposited directly into your bank account, provide the banking information below. A sample check is provided to help you locate the bank routing and bank account numbers.

Bank Routing Number | Bank Account Number | ☐ Checking ☐ Savings

Bank Name | Bank Phone Number

First Name | MI | Last Name

The **bank routing number** is always 9 digits and appears between the ⑆ symbols



The **bank account number** varies in length and may contain dashes or spaces. The ⑈ symbol indicates the end of the account number.

Bank Routing Number **Bank Account Number** **Check Number (not needed)**

CLAIM FOR TRAUMATIC INJURY PROTECTION (TSGLI) PAYMENT

Clear Form Print Form

Service member's Social Security Number

PART A - Member's Identifying Information and Authorization (cont'd) - to be completed by the member, guardian or attorney-in-fact

3 Payment Information (cont'd)

☐ **Payment Option 2 - Prudential's Alliance Account®*** (not available to guardian or attorney-in-fact) To have the payment deposited into an interest-bearing account and receive a checkbook, fill in the mailing address below (street address only, no PO Boxes).

Mailing Address for Payment - No P.O. Boxes

Apartment, Ward or Room (if any)

City

State

ZIP Code

☐ **Payment Option 3 - Check** (not available to member) – select this option to have a check mailed to the guardian or attorney-in-fact.

4 Signature

X

Signature of service member, guardian, or Attorney-in-fact

Date (MM DD YYYY)

Description of Authority

I certify that the loss I am claiming is not a result of any of the following: an attempted suicide; an intentionally self-inflicted injury or any attempt to inflict such injury; medical or surgical treatment of illness whether the loss results directly or indirectly; a traumatic event directly attributable to being under the influence of an illegal or controlled substance(s) unless administered or consumed on the advice of a doctor; sustained while committing or attempting to commit a felony; or an illness or disease (except for pyogenic infection resulting from a traumatic injury or an illness or disease resulting from the accidental ingestion of a deliberately contaminated substance or an illness or disease arising from a chemical, biological, or radiological weapon). A pyogenic infection is a pus producing infection.

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

5 Authorization to Speak With Third Party

First Name

MI

Last Name

I hereby authorize my branch of service and/or OSGLI to discuss the details of my TSGLI claim and/or coverage, including personal financial and medical or other health information about me with the above named person and to provide such person with any medical record information in connection with my TSGLI claim and/or coverage.

X

Signature of service member

Date (MM DD YYYY)

Clear Form Print Form

Service member's Social Security Number

PART A - Member's Identifying Information and Authorization (cont'd) - to be completed by the member, guardian or attorney-in-fact.

6 Authorization for Release of Information to Branch of Service and Office of Servicemembers' Group Life Insurance

This authorization is intended to comply with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, medical examiner or other health care provider that has provided treatment, payment or services pertaining to:

First Name | MI | Last Name

Date of Birth (MM DD YYYY) | Social Security Number

or on my behalf ("My Providers") to disclose my entire medical record for me or my dependents and any other health information concerning me to the Branch of Service and Office of Service members' Group Life Insurance (OSGLI) and its agents, employees, and representatives. OSGLI is a division of The Prudential Insurance Company of America, headquartered in Newark, New Jersey. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to OSGLI.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This information is to be disclosed under this Authorization so that my Branch of Service and OSGLI may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have applied for with OSGLI.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to OSGLI at: 290 West Mount Pleasant Avenue, Livingston, NJ 07039. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that OSGLI has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical record, OSGLI may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this authorization.

*Limits, if any:

X

Signature of service member, guardian or Attorney-in-fact

Description of authority to act on behalf of the member

Date (MM DD YYYY)

NOTE: The branch of service may not have access to the member's medical documents. This release authorizes the branch of service and OSGLI to look at these records, but does not provide access to obtain these documents. The member is responsible for providing the medical documents upon request.

Clear Form Print Form

Service member's Last Name

Service member's Social Security Number

PART B - Medical Professional's Statement - to be completed by the attending medical professional, which includes: a licensed physician, optometrist, nurse practitioner, registered nurse or physician assistant acting within the scope of his/her practice. **Fill in information about each loss being claimed by the patient. Check yes or no in each section to indicate if that particular loss is being claimed. If the member is claiming inability to perform activities of daily living, complete the ADL Questionnaire on pages 10 and 11.**

1 Patient and Injury Information

First Name MI Last Name

Date of Injury (MM DD YYYY) What loss listed below is the patient claiming?

If patient is deceased, please provide:

Date of Death (MM DD YYYY) Time of Death ☐A.M. ☐P. M.

Cause of Death

2 Loss of Limbs or Digits

Is this claim for loss of limbs or digits? ☐ Yes ☐ No

If yes, please indicate the following:

Right hand at or above wrist	Date of Amputation (MM DD YYYY)	Left hand at or above wrist	Date of Amputation (MM DD YYYY)
Right foot at or above ankle	Date of Amputation (MM DD YYYY)	Left foot at or above ankle	Date of Amputation (MM DD YYYY)
Right thumb at or above the metacarpophalengeal joint	Date of Amputation (MM DD YYYY)	Left thumb at or above the metacarpophalengeal joint	Date of Amputation (MM DD YYYY)
Index finger of right hand at or above the metacarpophalengeal joint	Date of Amputation (MM DD YYYY)	Index finger of left hand at or above the metacarpophalengeal joint	Date of Amputation (MM DD YYYY)

3 Loss of Vision

Is this claim for loss of vision? ☐ Yes ☐ No

If yes, please indicate the following:

Best corrected visual acuity

Date of Observation (MM DD YYYY) Right Eye Left Eye Visual Field for right eye (degrees) Visual Field for left eye (degrees)

From what date has the visual acuity recorded above existed?

Right Eye (MM DD YYYY) Left Eye (MM DD YYYY)

If patient has suffered the anatomical loss of one or both eyes, give the date this occurred:

Right Eye (MM DD YYYY) Left Eye (MM DD YYYY)

In your medical opinion is the patient's loss of vision clinically stable and unlikely to improve? ☐ Yes ☐ No

4 Loss of Speech

Is this claim for loss of speech? ☐ Yes ☐ No

If yes, please indicate the following: Date of onset (MM DD YYYY)

Can the patient speak by voice or by whisper through normal organs of speech, (esphogeal speech and/or artificial appliances are not considered normal organs of speech)? ☐ Yes ☐ No

In your medical opinion is the patient's loss of speech clinically stable and unlikely to improve? ☐ Yes ☐ No

Clear Form Print Form

Service member's Last Name

Service member's Social Security Number

PART B - Medical Professional's Statement (con't) to be completed by the attending medical professional, which includes: a licensed physician, optometrist, nurse practitioner, registered nurse or physician assistant acting within the scope of his/her practice.

5 Loss of Hearing

Is this claim for loss of hearing? ☐ Yes ☐ No If yes, comments required in Block 11.

If yes, please indicate the following:

Hearing acuity - measured via pure tone audiometry by air conduction (without amplification device)

Date of observation (MM DD YYYY)

500 Hz		1000 Hz		2000 Hz		Average	
Right Ear	Left Ear	Right Ear	Left Ear	Right Ear	Left Ear	Right Ear	Left Ear
db	db	db	db	db	db	db	db

From what date has the hearing acuity recorded above existed?

Right Ear (MM DD YYYY) Left Ear (MM DD YYYY)

In your medical opinion is the patient's loss of hearing clinically stable and unlikely to improve? ☐ Yes ☐ No

6 Paralysis

Is this claim for paralysis? ☐ Yes ☐ No If yes, comments required in Block 11.

If yes, please indicate the following:

Type of Paralysis:

☐ Hemiplegia ☐ Quadriplegia ☐ Paraplegia

Date of onset of paralysis (MM DD YYYY)

In your medical opinion is the patient's paralysis clinically stable and irreversible? ☐ Yes ☐ No

7 Burns

Is this claim for burns? ☐ Yes ☐ No

If yes, please indicate the following:

Does the patient have third degree or worse burns to the:

Face? ☐ No ☐ Yes - Please indicate percentage of face affected ___ %

Body? ☐ No ☐ Yes - Please indicate percentage of body affected ___ %

8 Coma

Is this claim for coma? ☐ Yes ☐ No

If yes, please indicate the following:

Date of onset of coma (MM DD YYYY)

Duration of coma ☐ Less than 15 Days ☐ 15-29 Days ☐ 30-59 Days ☐ 60-89 Days ☐ 90 Days or more

Please classify severity of brain injury using Glasgow Coma Score at ___ 15 Days ___ 30 Days ___ 60 Days ___ 90 Days

9 Traumatic Brain Injuries

Is this claim for traumatic brain injury? ☐ Yes ☐ No

If yes, please indicate the following:

Did the traumatic brain injury render the patient completely dependent upon another person to perform at least two activities of daily living (bathing, maintaining continence, dressing, eating, toileting, and transferring)? ☐ Yes ☐ No

If yes, please complete the ADL questionnaire at the end of Part B on pages 10 and 11 to document the inability to perform activities of daily living as a result of traumatic brain injuries.

10 Other Traumatic Injuries

Is this claim for traumatic injuries other than those listed above in items 1 through 9? ☐ Yes ☐ No

If yes, please indicate the following:

Did the patient's injuries render the patient completely dependent upon another person to perform at least two activities of daily living (bathing, maintaining continence, dressing, eating, toileting, and transferring)? ☐ Yes ☐ No

If yes, please complete the ADL questionnaire at the end of Part B on pages 10 and 11 to document the inability to perform activities of daily living as a result of traumatic brain injuries.

Clear Form Print Form

Service member's Last Name

Service member's Social Security Number

PART B - Medical Professional's Statement (con't) to be completed by the attending medical professional, which includes: a licensed physician, optometrist, nurse practitioner, registered nurse or physician assistant acting within the scope of his/her practice. For all sections except the signature block, please type or print legibly.

11 Medical Professional's Comments

Use this block to provide any additional information about the patient's injuries.

12 Medical Professional's Information

Name of Attending Medical Professional (Please Print)

First Name MI Last Name

Medical Professional's Address (number and street) Suite

City State ZIP Code

Telephone Number Fax Number

E-mail Address

If civilian medical professional, please complete:

Specialty

License Number State of License

If military medical professional, please complete:

Rank Branch of Service

13 Medical Professional's Signature

☐ I have observed the patient's loss. ☐ I have not observed the patient's loss, but I have reviewed the patient's medical records.

This Medical Professional's Statement is based upon my examination of the patient and/or a review of pertinent medical evidence. I understand the patient and/or I may be asked to provide supporting documentation to validate eligibility under the law.

Date (MM DD YYYY)

X

Signature

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

Clear Form Print Form

Service member's Last Name

Service member's Social Security Number

Activities of Daily Living (ADL) Questionnaire

To the Medical Professional: If the patient's claim is for traumatic brain injury or other traumatic injuries not listed on the form, please complete this questionnaire to document the patient's inability to perform activities of daily living as a result of his/her injury. **NOTE:** Medical Professionals cannot certify in advance of loss (e.g. a future date for end date).

Please check one of the following…	And follow the appropriate instructions
☐ I have observed the patient's inability to perform daily activities.	Please complete the following questions and attach copies of medical records that support this claim.
☐ I have not observed the patient's inability to perform daily activities but I have reviewed the patient's medical records.	

Is this claim for inability to Bathe? ☐ Yes ☐ No If yes, please indicate the following

1. Is/Was the patient completely dependent upon another person including…
   a. taking a sponge bath ☐ Yes ☐ No c. taking a shower ☐ Yes ☐ No
   b. taking a tub bath ☐ Yes ☐ No
2. Is/Was the patient able to use accommodating equipment or adaptive behavior to get into and out of the tub/shower? ☐ Yes ☐ No
3. Is/Was the patient able to get into and out of a specially accomodating tub/shower? ☐ Yes ☐ No
4. Describe the specific physical limitations and how these limitations prevent the patient from performing this activity.
5. When did the patient's inability to perform this activity begin and end?
   Begin Date (MM DD YYYY) End Date (if applicable) (MM DD YYYY) Check here if inability is ongoing ☐

Is this claim for a lack of Continence? ☐ Yes ☐ No If yes, please indicate the following

1. Does/Did the patient experience any loss of…
   a. Bladder control? ☐ No ☐ Yes, please indicate_____times per ☐ day ☐ month
   b. Bowel control? ☐ No ☐ Yes, please indicate_____times per ☐ day ☐ month
2. Is/Was the patient completely dependent upon another person to...
   a. manage medical devices (e.g. catheter, colostomy bag)? ☐ Yes ☐ No
   b. change incontinence garments? ☐ Yes ☐ No
3. Describe the specific physical limitations and how these limitations prevent the patient from performing this activity.
4. When did the patient's inability to perform this activity begin and end?
   Begin Date (MM DD YYYY) End Date (if applicable) (MM DD YYYY) Check here if inability is ongoing ☐

Is this claim for inability to Dress? ☐ Yes ☐ No If yes, please indicate the following

1. Is/Was the patient completely dependent upon another person to dress/undress including…
   a. pulling shirt on or off (pull-over or button-type shirt)? ☐ Yes ☐ No c. fastening garments (buttons or zippers)? ☐ Yes ☐ No
   b. pulling pants on or off (pants, shorts or sweat pants)? ☐ Yes ☐ No d. securing equipment (braces, artificial limbs)? ☐ Yes ☐ No
2. Is/Was the patient able to use accommodating equipment or adaptive behavior to dress? ☐ Yes ☐ No
3. Describe the specific physical limitations and how these limitations prevent the patient from performing this activity.
4. When did the patient's inability to perform this activity begin and end?
   Begin Date (MM DD YYYY) End Date (if applicable) (MM DD YYYY) Check here if inability is ongoing ☐

REMINDER: Attach copies of any medical records that support this claim. **CLAIM FOR TRAUMATIC INJURY PROTECTION (TSGLI) PAYMENT**

Clear Form Print Form

Service member's Last Name

Service member's Social Security Number

Is this claim for inability to Eat? ☐ Yes ☐ No If yes, please indicate the following

1. Is/Was the patient completely dependent upon another person to get food or liquid nourishment into his/her mouth? ☐ Yes ☐ No
2. Does/Did the patient require use of a feeding tube or TPN? ☐ Yes ☐ No
3. Is/Was the patient able to take liquid nourishment by mouth through a straw or cup? ☐ Yes ☐ No
4. Describe the specific physical limitations and how these limitations prevent the patient from performing this activity. ☐ Yes ☐ No

5. When did the patient's inability to perform this activity begin and end?

Begin Date (MM DD YYYY) End Date (if applicable) (MM DD YYYY) Check here if inability is ongoing ☐

Is this claim for inability to Toilet? ☐ Yes ☐ No If yes, please indicate the following

1. Is/Was the patient completely dependent upon another person when toileting, including…
   a. getting on and off the toilet/commode/bedpan/urinal? ☐ Yes ☐ No
   b. wiping oneself and performing associated personal hygiene? ☐ Yes ☐ No
2. Does/Did the patient require constant bedpan usage for each time he/she needed to toilet? ☐ Yes ☐ No
3. Is/Was the patient able to use accomodating equipment or adaptive behavior to toilet? ☐ Yes ☐ No
4. Describe the specific physical limitations and how these limitations prevent the patient from performing this activity.

5. When did the patient's inability to perform this activity begin and end?

Begin Date (MM DD YYYY) End Date (if applicable) (MM DD YYYY) Check here if inability is ongoing ☐

Is this claim for inability to Transfer? ☐ Yes ☐ No If yes, please indicate the following

1. Is/Was the patient completely dependent upon another person when transferring, including…
   a. getting in and out of bed (e.g. needed to be lifted by another person)? ☐ Yes ☐ No
   b. getting in and out of a chair (e.g. needed to be lifted by another person)? ☐ Yes ☐ No
2. Is/Was the patient able to use accomodating equipment such as a cane, crutches, bed rails or adaptive behavior to steady oneself while moving between a bed and a chair? ☐ Yes ☐ No
3. Describe the specific physical limitations and how these limitations prevent the patient from performing this activity.

4. When did the patient's inability to perform this activity begin and end?

Begin Date (MM DD YYYY) End Date (if applicable) (MM DD YYYY) Check here if inability is ongoing ☐

I have examined the patient and/or reviewed pertinent medical evidence. Based on this examination/review, I certify that this patient was unable to perform the activity(ies) of daily living indicated above.

Name of Attending Medical Professional (please print) Medical Professional's Signature Date Signed

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

REMINDER: Attach copies of any medical records that support this claim.

Clear Form Print Form

Service member's Social Security Number

PART C - Certification by Branch of Service - to be completed by the branch of service TSGLI certifying official

1 Traumatic Event Information

Date of Traumatic Event (MM DD YYYY)

Was the service member on duty when the event occurred? ☐ Yes ☐ No

Time of Event-Please use Zulu time (HH MM) :

Hostile Action? ☐ Yes ☐ No

Geographic location where event occurred (Please give state, province, etc where applicable)

Description of Traumatic Event

If service member is deceased, please attach Report of Casualty (DD 1300) or Death Certificate and Form SGLV – 8286, indicating SGLI beneficiaries.

Date of Death (MM DD YYYY)

Cause of Death

2 Certification by Branch of Service

Does the member qualify for Traumatic Injury Protection (TSGLI) payment under 38 CFR 9.20?

☐ Yes ☐ No-If no, please check all reasons for denial.

- ☐ member was not covered under SGLI at the time of the traumatic event (please attach copy of SGLV 8286 declining coverage)
- ☐ member's loss was not a direct result of a traumatic event
- ☐ member's loss does not qualify under the TSGLI schedule of loss
- ☐ member did not survive for seven full days from the date of the traumatic event
- ☐ member is claiming a loss and did not suffer the loss within the proscribed period as defined by the regulation
- ☐ member's loss was due to a traumatic injury willfully caused by member's own actions
- ☐ member's loss was due to a physical or mental illness or disease other than those covered by TSGLI
- ☐ member's loss was sustained while committing, or attempting to commit, a felony
- ☐ member's loss was sustained while attempting to commit suicide
- ☐ member's loss was caused by willful use of an illegal or controlled substance not prescribed by a doctor
- ☐ sufficient medical evidence was not provided
- ☐ other (please specify)

Comments

Are you aware of a guardian or attorney-in-fact being appointed for the service member? ☐ Yes ☐ No

3 Certifying Signature

Name and rank or civilian title of person certifying sections 1 and 2 above.

First Name MI Last Name

Rank or Civilian Title

Telephone Number

Certifying/Contact Office Name

E-mail Address

Date (MM DD YYYY)

X

Signature of person certifying sections 1 and 2 above

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

Clear Form Print Form

Service member's Social Security Number

PART C - Certification by Branch of Service - to be completed by the branch of service TSGLI certifying official

4 Additional Comments
(if any)